Medical Examiner Department
Public Interment Program
(FAX: 305-545-2409)

Verification of No Next of Kin Affidavit

PERSONAL INFORMATION

Name of Deceased (First/Middle/Last)	Gender: ☐ M ☐ F	SSN:
Marital status: ☐ Married ☐ Married but Separated ☐ Never Married ☐ Divorced ☐ Widowed		
Date of Death: [Month/Day/Year]	Date of Birth:	Age:

DECEDENT'S RACE

(Specify the race/races to indicate what decedent considered himself/herself to be).

	☐ White	☐ American Indian	☐ Korean	☐ Japanese
	☐ Black	☐ Chinese	☐ Vietnamese	☐ Other Asian
	☐ Asian Ind	☐ Filipino	☐ Native Hawaiian	☐ Other [Please specify]

Decedent of Hispanic or Haitian origin? ☐ yes ☐ no (if yes, specify) **☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Central/South American ☐ Other ☐ Other Hispanic** (*specify*) **:** **☐ Haitian**

Last Known Address: _____

Place of Birth: (City/State) _____

Decedent's Usual Occupation: _____ Was the decedent ever in the U.S. Armed Forces? ☐ yes ☐ no

Eye and Hair Color: →	Eyes: Hair:	Height: Ft. In. Weight: Lbs
Tattoos/Scars(*Describe)* →		Photo Identification: ☐ yes ☐ no (If yes, please return copy with this form)
Medical Information		
Time of Death	Hospital/Nursing Home/Other (Place of Death) ↓	Form Completed By ↓
A.M. P.M.		Name:
Physician's Phone Number (Certifier): →		Title:
Physician's Name: →		Telephone Number:
Physician's Address: →		

Attention: Please use the space below to document your investigative efforts. Use additional paper if needed.